**Behavioral Health Integration Workgroup Meeting Notes** *03.27.2019*

Participants:

Charles Gross Anthem

Ronald Szabat American Academy of Child & Adolescent Psychiatry

Beth Sweeney Anthem

Diane Padden American Association of Nurse Practitioners

Jennifer Flynn Johnson & Johnson

Kathy Pham American College of Clinical Pharmacy

Scott Feeser Johns Hopkins Community Physicians, Inc.

Carol Alter Mental Health Association of Maryland

Michelle Dirst American Psychiatric Association

Susan McDaniel University of Rochester Medical Center

Junqing Liu National Committee for Quality Assurance

Larry McNeely American Diabetes Association

Ann Greiner PCPCC

Chris Adamec PCPCC

Alyssa Neumann Kane PCPCC

*A few others may have joined late on the phone or were not identified*

After a welcome by workgroup co-chairs Ron Szabat and Charlie Gross, PCPCC CEO Ann Greiner opened up the meeting providing with three updates to attendees:

* First, she updated attendees on an exciting primary care investment convening in Massachusetts, hosted by the MA medical society, at which medical schools, public health practitioners, FQHCs, and consumer organizations were all represented. Part of their central vision was to achieve behavioral health integration.
* Second, she brought up that the conference planning committee agreed that there should be a behavioral health integration session at the fall conference and emphasized an opportunity for the Behavioral Health and Primary Care Workgroup to shape what that session should look like.
* Lastly, she shared with participants new book, “Integrated Behavioral Health in Primary Care: Your Patients are Waiting” written by two family medicine practitioners (Stephanie B. Gold and Larry A. Green) on primary care and behavioral health integration. The book acts as a guide of primary care clinicians on best practices for integrating behavioral health into their practices. It is based on a study of 13 practices over a 3-year period in Denver, Colorado. Given interest from workgroup participants, PCPCC reached out to the authors about purchasing copies and will share information with members.

Ron then mentioned that he was excited about the news in Massachusetts and noted that we should consider lessons learned from our work with Delaware to figure out what elements could be transferrable to work in Massachusetts.

Planning for Behavioral Health Integration in the 2019 Conference

Members discussed perspectives that could be interesting to have on a panel, including those providing guidance on integrating behavioral health into primary care.It would be beneficial to understand the perspective of the journey and challenges of this integration as well as someone strategic with “big picture” ideas on the issue.

It could also be compelling to have a quantitative discussion based on case studies with compelling results, or to have a conversation about workforce implications of better screening and capturing of behavioral health issues. There are also workforce limitations regarding different age groups, especially in pediatric behavioral health. Often, we know we need an intervention but may not have the available workforce to address it. Do we have the right people doing the right work in the right ways, and how does integrated care address this?

It was mentioned that while approaching the panel from a strategic perspective could be compelling, it makes the assumption that the audience is familiar with the topic. It would be important to provide some background or a combination of approaches before discussing strategy.

A topline view for the discussion could focus on the needs of primary care practices for integration because many realize they need to do something but have no idea where to begin. It was questioned whether there was an interaction opportunity to engage in primary care needs. It was then suggested that the panel be a structured conversation where we understand the expertise of the three speakers and know what they are going to hit on. We will want to look at lessons learned, the needs on the ground, and where we need to start. Ann then brought up the fact that there will be breakout rooms available at the conference so there is the possibility of having a more in-depth behavioral health integration workshop that could be more interactive and may be useful in getting the perspective of the primary care providers.

Ann then brought up that the conference planning committee was interested in the idea of bringing in a patient. Patients can articulate the real issues and why things need to change. Clinicians are responsive to patient stories, which can have a powerful effect on changing minds, and patient panels have historically been well-received.

The concept of threading behavioral health integration as an idea through the entire conference was then brought up. There will be a good opportunity to work behavioral health into the international population health panel. In the UK, they are mandating this type of integration so it would be interesting to get their perspective on it.

It was then brought up that we should be sure to reference the consensus recommendations in the app and the conference materials. We should also be thinking about what can be delivered in hard copy versus what needs to be verbal.

*It was decided that speakers would be chosen in May or June at the latest. We should come back to the next meeting with a concept for the session and suggestions of potential speakers to give to the conference planning committee.*

Primary Care and Behavioral Health Integration Case Studies

Moving on to the discussion of the evidence collection—discussed what may be missing; noting that we do not want to be too exhaustive and overwhelm them. Currently they are organized by costs versus outcomes. While we do not necessarily want to highlight cost savings as our priority, it can be an important factor to lobbyists and policymakers. Ann brought up the idea of organizing the studies in a way such as some other literature reviews that are standardized in a way that makes the very digestible, and easily understood at a glance. Chris also mentioned that we need to build on the comments a little bit more with additional narrative and explication.

Chris then asked for any thoughts on the draft consensus recommendations, which have gone over a month without comments. It was decided to take it out of draft for form limited use in Delaware and then later go back and tweak it for use in Massachusetts. The plan is to give it to Delaware and ask them if it is the right kind of tool for them.

Other:

The American Diabetes Association discussed with members the importance of behavioral health integration for patients with diabetes. They are currently working on plans for how they can best leverage the patient voice to support this work.